Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2024

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: October 25, 2023

Dear Administrator:

On January 2, 2023, we notified you a remedy was imposed. On December 19, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 19, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 25, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 2, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 25, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 19, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On October 23 - 25, 2023, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed and found in Compliance with NO deficiencies cited: HE3556544C (MN00094637). HE3556545C (MN00096565). HE3556546C (MN00090175). HE3556547C (MN00094639). HE3556548C (MN00089530). HE3556549C (MN00096564). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		12/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 1 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly store a portable oxygen tank for 1 of 1 resident (R9) who utilized oxygen. R9's significant change Minimum Data Set (MDS) dated 10/6/23 indicated that R9 had moderately impaired cognition. R9's diagnoses included chronic obstructive pulmonary disease, shortness of breath and chronic systolic (congestive) heart failure. On 10/23/23 at 3:08 p.m., a portable oxygen tank, with regulator attached, was freestanding next to the heating vent near the window in R9's room. Portable oxygen tank was not stored in a secure cart. On 10/24/23 at 11:30 a.m. and 2:29 p.m., portable oxygen tank remained in same location, freestanding and not secured. On 10/24/23 at 11:55 a.m., nursing assistant (NA)-A stated portable oxygen tanks should be stored in the oxygen room. On 10/24/23 at 6:14 p.m., director of nursing (DON) stated portable oxygen tanks should be stored in the oxygen room. If a resident utilized a portable oxygen tank, it should be stored in a secure wheeled cart. DON confirmed that the portable tank, in R9's room, was unsecured and removed tank from room. DON stated it was important for a portable oxygen tank to be stored	F 695	THIS REMOVAL PLAN CONSTITUTES OUR WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCY CITED. HOWEVER, THE SUBMISSION OF THIS PLAN OF CORRECTION IS NOT AN ADMISSION THAT THE DEFICIENCIES EXIST OR THAT THEY WERE CORRECTLY CITED. THIS PLAN OF CORRECTION IS SUBMITTED TO COMPLY WITH STATE AND FEDERAL LAWS. F695 During the annual survey, the survey team was emailed a copy of the facility's Oxygen Storage policy. The Interdisciplinary Team (IDT) subsequently reviewed the policy. On the day of the Director of Nursing's (DON) interview, the said oxygen tank was placed in a portable oxygen tank safety unit and secured in the facility□s oxygen storage room. Furthermore, a comprehensive search of the building was conducted by the DON and did not uncover any additional free-standing oxygen tanks. It was determined that the Oxygen tank had been left in the room by R9□s hospice provider. All residents who are on oxygen have the potential to be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 2 in a secure cart because if a tank fell down or get knocked over, it could explode like a weapon. A policy for Storage of Portable Oxygen was requested and was not received.	F 695	R9□s hospice provider will be educated on the facility□s Oxygen Storage policy. All licensed staff, TMAs, and CNAs will be re-educated by the DON, ADON, or designee on the facility□s Oxygen Storage Policy. The Director of Nursing, Assistant Director of Nursing, or a designated representative will conduct weekly audits for 5 residents on oxygen, evaluating the proper storage and securement of oxygen tanks for 30 days, 3 weekly for 30 days, and 2 weekly for 30 days for a total of 90 days. Simultaneously, audits will be conducted for 5 staff members evaluating their familiarity with the facility's Oxygen Storage Policy per week for 30 days, 3 weekly for 30 days, and 2 weekly for 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 3 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacist consultant monitored facility's ongoing psychotropic side effect monitoring for 3 of 5 residents (R26, R9, R42) reviewed for unnecessary medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 8/23/23 indicated R26 was cognitively intact, had diagnoses of stroke, peripheral vascular disease, dementia, anxiety, depression and psychotic	F 756	F756 The facility has conducted updated AIMS assessments for R26, R9, R42. To ensure the currency of all AIMS assessments, the facility will review and update assessments for all residents on psychotropic medications. To ensure the currency of all AIMS assessments, the facility will review and update assessments for all residents on psychotropic medications by the specified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 4 disorder. R26's MDS further indicated resident was not receiving antipsychotic medications. A review of R26's medication orders (print date of 10/25/23) indicated R26 received Risperdal (antipsychotic) 1.25 milligrams (mg) in total daily. R26's Consultant Pharmacist's monthly Medication Review, from 1/05/23 through dated 10/23, indicated only one recommendation was made for a gradual dose reduction of R26's duloxetine (antidepressant - Cymbalta) in February 2023 . R26's physician orders dated (print date of 10/25/23) indicated R26 had an order for Risperdal 1.25 mg on 8/14/23. In review of R26's medication history the following was noted. R26 was admitted 5/24/22 with the order for Risperdal 1.25 mg daily. In May 2023, R26's Resperdal wad discontinued and then restarted on 8/14/23 at the same dose. In review of R26's electronic medical record, the only AIMS (Abnormal Involuntary Movement Scale - a tool used to monitor for tardive dyskinesia - side effected from psychotropic medications), dated 5/24/22, when R26 was admitted to the facility. During interview on 10/25/23 at 8:35 a.m., MDS coordinator (RN)-A stated the facility only had evidence of one AIMS being completed for R26 at the time of resident's admission. RN-A stated that he knew the AIMS assessment should be completed at the time of admission and every 6 months when a resident is receiving an antipsychotic medication, but relied on the	F 756	completion date. AIMS assessment will be reviewed quarterly to ensure compliance. The facility will be updating the AIMS policy for assessments to be completed on a quarterly basis. The facility will ensure that the consulting pharmacist monitors the facility's ongoing antipsychotic side effect monitoring AIMS during his monthly review of unnecessary medications. To ensure the pharmacist's compliance, 5 resident pharmacy reviews will be audited for 30 days, then 3 residents for 30 days, then 2 residents for 30 days for a total of 90 days All residents on psychotropic medications have the potential for developing Tardive Dyskinesia. Licensed Staff with the job duties that include AIMS assessments will be educated on the proper procedures for completing within 3 months or quarterly to ensure compliance. The DON or designee will review and note compliance during care conferences. The DON, ADON, or designee will audit AIMS to ensure compliance with the 6-month review by auditing 5 residents on psychotropic medications per week x 30 days, 3 residents per week x 30 days, and 2 residents per week for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 5 pharmacy consultant to remind him through monthly recommendations. In a telephone interview on 10/25/23 at 3:19 p.m., consultant pharmacist (PharmD) stated residents should have an AIMS completed upon initiation of an antipsychotic medication and then every 6 months after. PharmD stated he "generally makes recommendation for AIMS to be completed by doing 'spot checks' when performing monthly medication reviews." PharmD stated the facility should have polices in place to director AIMS assessments. PharmD further stated he would be keeping a closer watch on this and add to his "to do list." Findings include: R9's quarterly Minimum Data Set (MDS) dated 8/2/23 indicated R9 was cognitively intact, had diagnoses of non-Alzheimer's dementia, depression, and psychotic disorder. A review of R9's medication orders (print date of 10/24/23) indicated R9 received Zyprexa (antipsychotic) 15 milligrams (mg) in total daily. R9's Consultant Pharmacist's monthly Medication Review, from 1/05/23 through dated 10/23, did not include recommendations for an abnormal involuntary movement scale (AIMS) assessment. to be completed. In review of R9's electronic medical record, R9 had AIMS assessments completed on 11/3/21 and 8/29/22 and has not had another assessment completed since 8/29/22.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 6 R42's annual MDS dated 9/20/23 indicated R42 had severe cognitive impairment, had diagnoses of Alzheimer's disease, anxiety, and depression. A review of R42's medication orders (print date of 10/24/23) indicated R42 received Seroquel (antipsychotic) 125 mg in total daily. R42's Consultant Pharmacist's monthly Medication Review, from 1/05/23 through dated 10/23, did not include recommendations for an AIMS assessment to be completed. In review of R42's electronic medical record, the only AIMS assessment was completed on 12/19/22 and has not had another assessment completed since 12/19/23. On 10/25/23 at 9:45 a.m., RN-A stated he is the person responsible for completing the AIMS assessments and that they should be completed on admission and every 6 months if a resident is receiving an antipsychotic medication. RN-A confirmed that R9 last AIMS assessment was completed on 8/29/22 and R42's was completed on 12/19/23. In review of another facility policy, entitled: Pharmacy Services - Consultant Pharmacist Services Requirements - Thrifty White Pharmacy (revised January 2020) indicated the following: Section E., subsection 6: "Assist in identifying current medication references to facilitate medication information on contraindications, side effects and/or adverse effects, dosage levels and other information." Section F, subsection 2: "Communicating to	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 7 leadership the potential or actual problems detected and other findings related to medication use at least monthly."	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were routinely assessed for tardive dyskinesia were collected to allow adequate monitoring of potential side effects for physician ordered antipsychotic medications for 3 of 5 residents (R26, R9, R42) reviewed for unnecessary medication use.	F 757	F757 The facility has conducted updated AIMS assessments for R26, R9, R42. To ensure the currency of all AIMS assessments, the facility will review and update assessments for all residents on psychotropic medications. The facility has	12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 8 Findings include: R26's quarterly Minimum Data Set (MDS) dated 8/23/23 indicated R26 was cognitively intact, had diagnoses of stroke, peripheral vascular disease, dementia, anxiety, depression and psychotic disorder. R26's MDS further indicated resident was not receiving antipsychotic medications. A review of R26's medication orders (print date of 10/25/23) indicated R26 received Risperdal (antipsychotic) 1.25 milligrams (mg) in total daily (oder date of 8/14/23). In review of R26's medication history the following was noted. R26 was admitted 5/24/22 with the order for Risperdal 1.25 mg daily. In May 2023, R26's Resperdal wad discontinued and then restarted on 8/14/23 at the same dose. In review of R26's electronic medical record, the only AIMS (Abnormal Involuntary Movement Scale - a tool used to monitor for tardive dyskinesia - side effected from psychotropic medications), dated 5/24/22, when R26 was admitted to the facility. During interview on 10/25/23 at 8:35 a.m., MDS coordinator (RN)-A stated the facility only had evidence of one AIMS being completed for R26 at the time of resident's admission. RN-A stated that he knew the AIMS assessment should be completed at the time of admission and every 6 months when a resident is receiving an antipsychotic medication, but relied on the pharmacy consultant to remind him through monthly recommendations. In a telephone interview on 10/25/23 at 3:19 p.m.,	F 757	conducted updated AIMS assessments for R26, R9, R42. To ensure the currency of all AIMS assessments, the facility will review and update assessments for all residents on psychotropic medications by the specified completion date. AIMS assessment will be reviewed quarterly to ensure compliance. The facility will be updating the AIMS policy for assessments to be completed on a quarterly basis. All residents on psychotropic medications have the potential for developing Tardive Dyskinesia. Licensed Staff with the job duties that include AIMS assessments will be educated on the proper procedures for completing within 3 months or quarterly to ensure compliance. The DON or designee will review and note compliance during care conferences. The DON, ADON, or designee will audit AIMS to ensure compliance with the 6-month review by auditing 5 residents on psychotropic medications per week x 30 days, 3 residents per week x 30 days, and 2 residents per week for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 9 consultant pharmacist (PharmD) stated residents should have an AIMS completed upon initiation of an antipsychotic medication and then every 6 months after. PharmD stated he "generally makes recommendation for AIMS to be completed by doing 'spot checks' when performing monthly medication reviews." PharmD stated the facility should have polices in place to direct AIMS assessments. PharmD further stated he would be keeping a closer watch on this and add to his "to do list." R9's quarterly Minimum Data Set (MDS) dated 8/2/23 indicated R9 was cognitively intact, had diagnoses of non-Alzheimer's dementia, depression, and psychotic disorder. A review of R9's signed physician medication orders (print date of 10/24/23) indicated R9 received Zyprexa (antipsychotic) 7.5 milligrams (mg) twice daily. R9's electronic medical record (EMR) included AIMS assessment compled on 11/3/21 and 8/29/22. The EMR lacked additional AIMS assessments. R42's annual MDS dated 9/20/23 indicated R42 had severe cognitive impairment, had diagnoses of Alzheimer's disease, anxiety, and depression. A review of R42's signed physician medication orders (print date of 10/24/23) indicated R42 received Seroquel (antipsychotic) 125 mg in total daily. R42's electronic medical record (EMR) included AIMS assessment compled 12/19/22. The EMR	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 10 lacked additional AIMS assessments. On 10/25/23 at 9:45 a.m., RN-A stated he is the person responsible for completing the AIMS assessments and that they should be completed on admission and every 6 months if a resident is receiving an antipsychotic medication. RN-A confirmed that R9 last AIMS assessment was completed on 8/29/22 and R42's was completed on 12/19/22. The facility policy, entitled: AIMS Assessment for Dyskinesias (reviewed 8/31/23) indicated the following: "This policy and procedure for AIMS assessment for dyskinesias will be followed by Registered Nurses in our facility as part of routine clinical evaluations for patients taking neuroleptic medications. The results will be used for monitoring and providing appropriate care to patients experiencing dyskinesias. This will be completed on admission, every 6 months (per pharmacist), or as needed if a change in neuroleptic medications."	F 757		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff.	F 851		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 11 Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 12 information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to submit complete and accurate direct care staffing information, including information for agency and contract staff, during 1 of 1 quarters (Quarter 3: April 1 - June 30, 2023), reviewed for payroll based journal (PBJ). Findings include: Review of the staffing schedules and timecard verifications for Quarter 3 identified the facility had licensed nursing staff, 24 hours per day 7 days per week, and 8 consecutive hours per 24 hours of registered nurse (RN) coverage documented. However, during interview on 10/26/23 at 10:30 a.m., administrator and and business office lead (BusO) both stated they used SimplePBJ (a Payroll Based Journal computer application) when submitting their staffing levels on a quarterly basis. Both staff members stated that BusO was the responsible staff person that submitted the PB&J data for the facility. Both staff stated they were unable to provide a verification email, which would indicate the facility's 2023 3rd quarter PB&J had been submitted. At 2:15 p.m., BusO was able to show the data had been completed, however was undated, and BusO was unable to provide the standard verification email	F 851	F851 The facility had completed all of the required PBJ staffing information for quarter 3. The facility uses a clearing house called SimplePBJ to submit the data to CMS on a quarterly basis. SimplePBJ did not supply a confirmation to Aftenro that the 3rd quarter data had been submitted. Aftenro submitted the quarterly data using Central Standard Time rather than Eastern Time causing the submission to be late. Therefore the data submission was not accepted by CMS. Going forward, SimplePBJ will be supplying Aftenro with a confirmation letter and also they will be supplying Aftenro with the CMS confirmation letter stating that the data was accepted by CMS. The facility has become aware that the submission has to be completed by the Eastern Time deadline. The Assistant Administrator is responsible for the timely submission of the PBJ data. SimplePBJ will be providing the Administrator and the Assistant Administrator the confirmation notices. Q4 2023 data was submitted and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 13 letter which SimplePBJ send out, verifying a facility's data had been received. On 10/25/23 at 4:15 p.m., exit conference was held. No further information was provided by the facility.	F 851	confirmations were received by both the Administrator and the Assistant Administrator. The confirmations will be shared with the QAPI committee at the next monthly QAPI meeting in December of 2023.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 14, 2023

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: October 25, 2023

Dear Administrator:

On October 25, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Stassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 25, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 25, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/30/2023. At the time of this survey, Aftenro Home Duluth was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Aftenro Home is a 3-story building with no basement. The building was constructed at 4 different times. The original 3 story building was constructed in 1921 and was determined to be of Type II(222) construction. In 1935, a 3 story addition was constructed to the North that was determined to be of Type II(222) construction. In 1990, a 2 story addition was constructed to the East that was determined to be of Type II(222) construction. In 2001, a 1 story addition was constructed above the 1990 East addition that	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 was determined to be of Type II(222) construction. Because the original building and the 3 additions are of the same type of construction, the facility was surveyed as one building. The facility has a capacity of 54 beds and had a census of 50 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: 1) On 10/30/2023 at 10:36am, it was revealed by observation that storage room 341 did not have a self-closing device. 2) On 10/30/2023 at 11:09am, it was revealed by observation that storage room (Garden Center) did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 1. Room 341 was being used for temporary storage. Room 341 will be emptied of the excess material that had been stored in that space. It is intended to become an office. 2. The garden center room will have a door closer installed keeping this area closed off from the hall way at all times. 3. The Maintenance Engineer is responsible for these corrections. The Maintenance Engineer or designee with monitor these rooms and all room for changes that may change the fire rating of those rooms.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 4 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 10/30/2023 at 10:18am, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed	K 324	K324 The facility did test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. The kitchen hood was inspected per the regulation. The dates of inspection and cleaning were as follows: 1/13/2023 inspection 7/31/2023 cleaning 8/15/2023 inspection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 5 test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	These inspections were performed by Northland Fire & Safety. The documentation was in the facility 2023 Life Safety documentation book at the time of inspection, but may have been overlooked by the LSC surveyor during his review. The Maintenance Engineer is responsible for scheduling these inspections and obtaining documentation of such inspections. Going forward, the Maintenance Engineer will review the binder for the needed documentation on a quarterly basis. In the future we will print out any additional requested documentation and provide them to the LSC surveyor prior to the exit.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 6 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/30/2023 at 10:17am, it was revealed by a review of available documentation the facility failed to provide documentation of the annual sprinkler system testing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 351	K 351 the facility does maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. The annual sprinkler system inspection was performed on 2/22/2023 by Fire Pro within the correct time. The inspection report was not in the facility maintained Life Safety documentation book at the time of inspection. A copy was readily available to give to the fire marshal had the Maintenance Engineer been allowed time to print a copy from his desk top computer. Going forward, the Maintenance Engineer will review the binder for the needed documentation on a quarterly basis. In the future we will print out any additional requested documentation and provide them to the LSC surveyor prior to the exit.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 7 inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/30/2023 at 10:23am, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	K355 The facility does maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. The annual inspection of the portable fire extinguishers was performed in the correct time frame. This inspection was done on 8/17/2023 by Northland Fire and Safety. A copy of this report was not in the facility 2023 Life Safety documentation book at the time of inspection and it is not required to be maintained in the book. However a copy could have been printed from the Maintenance Director's desk top computer had he been allowed time to print a copy of it at the time of inspection. The Maintenance Engineer is responsible to see that this inspection is scheduled in a timely manner. Going forward, the Maintenance Engineer will review the binder for the needed documentation on a quarterly basis. In the future we will print out any additional requested documentation and provide them to the LSC surveyor prior to the exit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 8	K 712		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/30/2023 at 10:12am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: first shift 05/30/2023 at 13:37pm, 08/22/2023 at 13:37pm. On 10/30/2023 at 10:12am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: first shift 11/20/2022 at 9:26am, 02/08/2023 at 9:39am.	K 712	K 712 The fire drill schedule will be adjusted to ensure that the drill times will be varied by at least two hours from the previous drill. This schedule is in the in the facility Life Safety documentation book and fire drill document book. The Administrator will be responsible and monitor that the drills are conducted at varied times.	12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 9 On 10/30/2023 at 10:12am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 3/18/23 at 20:46pm, 06/26/2023 at 21:16pm, 09/29/2023 at 21:37pm and 12/6/22 at 21:50pm An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 10 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/30/2022, at 10:00am, it was revealed by a review of available documentation of the emergency generator maintenance that the 36 month, 4 hour load back test could not be provided. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 918	K918 The every 36 month 4 hour load bank test has been added to the Allied Generator(Aftenro vendor) task list. The 4 hour load bank test will be performed in the following years going forward 2026, 2029, 2032 etc. This test will occur during the annual inspection and before the 36 month window closes. The test reports will be kept in the facility Life Safety documentation book. A time line tag will be attached to the generator as well as in the generator log book to ensure compliance with this long duration time period. The 4 hour load bank test was completed on 11/13/2023. The Maintenance Engineer or designee is responsible for monitoring for compliance.	